

§ 2590.731

the in-network 20% coinsurance, is \$92.80; and the Medicare payment is \$80. Thus, the greatest amount is \$92.80. The individual is responsible for the remaining \$32.20 charged by the out-of-network provider.

Example 6. (i) Facts. Same facts as *Example 5*. The group health plan generally imposes a \$250 deductible for in-network health care. With respect to all health care provided by out-of-network providers, the plan imposes a \$500 deductible. (Covered in-network claims are credited against the deductible.) The individual has incurred and submitted \$260 of covered claims prior to receiving the emergency service out of network.

(ii) *Conclusion.* In this *Example 6*, the plan is not responsible for paying anything with respect to the emergency service furnished by the out-of-network provider because the covered individual has not satisfied the higher deductible that applies generally to all health care provided out of network. However, the amount the individual is required to pay is credited against the deductible.

(4) *Definitions.* The definitions in this paragraph (b)(4) govern in applying the provisions of this paragraph (b).

(i) *Emergency medical condition.* The term *emergency medical condition* means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). (In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.)

(ii) *Emergency services.* The term *emergency services* means, with respect to an emergency medical condition—

(A) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(B) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

(iii) *Stabilize.* The term *to stabilize*, with respect to an emergency medical condition (as defined in paragraph (b)(4)(i) of this section) has the meaning given in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(c) *Applicability date.* The provisions of this section apply for plan years beginning on or after September 23, 2010. See § 2590.715–1251 of this part for determining the application of this section to grandfathered health plans (providing that these rules regarding patient protections do not apply to grandfathered health plans).

[75 FR 37232, June 28, 2010]

Subpart D—General Provisions Related to Subparts B and C

SOURCE: 62 FR 16941, Apr. 8, 1997, unless otherwise noted. Redesignated at 65 FR 82142, Dec. 27, 2000.

§ 2590.731 Preemption; State flexibility; construction.

(a) *Continued applicability of State law with respect to health insurance issuers.* Subject to paragraph (b) of this section and except as provided in paragraph (c) of this section, part 7 of subtitle B of Title I of the Act is not to be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

(b) *Continued preemption with respect to group health plans.* Nothing in part 7 of subtitle B of Title I of the Act affects or modifies the provisions of section 514 of the Act with respect to group health plans.

(c) *Special rules—(1) In general.* Subject to paragraph (c)(2) of this section, the provisions of part 7 of subtitle B of

Title I of the Act relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 701 which differs from the standards or requirements specified in such section.

(2) *Exceptions.* Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

(i) Shortens the period of time from the “6-month period” described in section 701(a)(1) of the Act and §2590.701-3(a)(2)(i) (for purposes of identifying a preexisting condition);

(ii) Shortens the period of time from the “12 months” and “18 months” described in section 701(a)(2) of the Act and §2590.701-3(a)(2)(ii) (for purposes of applying a preexisting condition exclusion period);

(iii) Provides for a greater number of days than the “63-day period” described in sections 701(c)(2)(A) and (d)(4)(A) of the Act and §§2590.701-3(a)(2)(iii) and 2590.701-4 (for purposes of applying the break in coverage rules);

(iv) Provides for a greater number of days than the “30-day period” described in sections 701(b)(2) and (d)(1) of the Act and §2590.701-3(b) (for purposes of the enrollment period and preexisting condition exclusion periods for certain newborns and children that are adopted or placed for adoption);

(v) Prohibits the imposition of any preexisting condition exclusion in cases not described in section 701(d) of the Act or expands the exceptions described therein;

(vi) Requires special enrollment periods in addition to those required under section 701(f) of the Act; or

(vii) Reduces the maximum period permitted in an affiliation period under section 701(g)(1)(B) of the Act.

(d) *Definitions*—(1) *State law.* For purposes of this section the term *State law* includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of

the United States applicable only to the District of Columbia is treated as a State law rather than a law of the United States.

(2) *State.* For purposes of this section the term *State* includes a State (as defined in §2590.701-2), any political subdivisions of a State, or any agency or instrumentality of either.

[69 FR 78778, Dec. 30, 2004; 70 FR 21147, Apr. 25, 2005]

§2590.732 Special rules relating to group health plans.

(a) *Group health plan*—(1) *Defined.* A group health plan means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) *Determination of number of plans.* [Reserved]

(b) *General exception for certain small group health plans*—(1) Subject to paragraph (b)(2) of this section, the requirements of this part do not apply to any group health plan (and group health insurance coverage) for any plan year, if on the first day of the plan year, the plan has fewer than two participants who are current employees.

(2) The following requirements apply without regard to paragraph (b)(1) of this section:

(i) Section 2590.701-3(b)(6) of this Part.

(ii) Section 2590.702(b) of this Part, as such section applies with respect to genetic information as a health factor.

(iii) Section 2590.702(c) of this Part, as such section applies with respect to genetic information as a health factor.

(iv) Section 2590.702(e) of this Part, as such section applies with respect to genetic information as a health factor.

(v) Section 2590.702-1(b) of this Part.

(vi) Section 2590.702-1(c) of this Part.

(vii) Section 2590.702-1(d) of this Part.

(viii) Section 2590.702-1(e) of this Part.

(ix) Section 2590.711 of this Part.

(c) *Excepted benefits*—(1) *In general.* The requirements of this Part do not apply to any group health plan (or any